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J. Epidemiol. Community Health 2006;60;405-411
doi:10.1136/jech.2005.040345

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EVIDENCE BASED PUBLIC HEALTH POLICY AND PRACTICE

Quitting smoking and experience of smoking cessation interventions among UK Bangladeshi and Pakistani adults: the views of community members and health professionals

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J Epidemiol Community Health 2006;**60**:405–411. doi: 10.1136/jech.2005.040345

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Accepted for publication 22 December 2005

Objective: To explore attitudes to quitting smoking and experience of smoking cessation among Bangladeshi and Pakistani ethnic minority communities.

Design: Qualitative study using community participatory methods, purposeful sampling, interviews and focus groups, and a grounded approach to data generation and analysis.

Setting: Newcastle upon Tyne, UK, 2000–2002.

Participants: 53 men and 20 women aged 18–80 years, including smokers, former smokers, and smokers' relatives, from the Bangladeshi and Pakistani communities; and eight health professionals working with these communities.

Results: Motivation to quit was high but most attempts had failed. "Willpower" was the most common approach to quitting. For some, the holy month of Ramadan was used as an incentive, however few had been successful in quitting. Perceived barriers to success included being tempted by others, everyday stresses, and withdrawal symptoms. Few participants had sought advice from health services, or received cessation aids, such as nicotine replacement therapy (NRT) or bupropion. Family doctors were not viewed as accessible sources of advice on quitting. Health professionals and community members identified common barriers to accessing effective smoking cessation, including: language, religion and culture; negative attitudes to services; and lack of time and resources for professionals to develop necessary skills.

Conclusions: High levels of motivation do not seem to be matched by effective interventions or successful attempts to quit smoking among Bangladeshi and Pakistani adults in the UK. There is a need to adapt and test effective smoking cessation interventions to make them culturally acceptable to ethnic minority communities. UK tobacco control policies need to give special attention to the needs of ethnic minority groups.

Smoking prevalence among Bangladeshi men (49%) is significantly higher than among Pakistani (28%), Indian (19%), or white men in the UK (29%).^{1–4} Rates among Bangladeshi (4%) and Pakistani (2%) women are reportedly low,^{3,4} but this situation is changing as teenage girls from these communities are increasingly taking up smoking.⁵

We have previously found smoking in these communities is strongly influenced by age and sex, as well as cultural factors, including religion and traditions, which increase its social acceptability.^{6,7} There is little published research on smoking cessation in Pakistani and Bangladeshi people in the UK, although practice reviews provide evidence of locally based projects and conclude that although motivation to quit is high, both access to cessation services and quit rates are low.^{8–10} Stop smoking services have been developed extensively in the UK since 1999, underpinned by the government's tobacco control white paper.¹¹ Locally, in Newcastle upon Tyne, at the time of the fieldwork for this study, community based smoking cessation advisors from ethnic minority groups were being trained as a part of a health action zone initiative.

We report here the second phase of a community based qualitative study,^{6,7} involving interviews and focus groups with members of UK Pakistani and Bangladeshi communities and health professionals working with these communities. We aimed to: gain understanding of attitudes to quitting smoking; identify experiences of smoking cessation interventions; and elicit perceived opportunities for, and barriers to, reducing smoking among Bangladeshi and Pakistani

adults, so as to inform tobacco control policy locally and nationally.

METHODS

Overview of methods

The methods have been described in some detail.⁷ Ethical approval was obtained from Newcastle and North Tyneside joint local research ethics committee. We used a community participatory research approach previously developed with ethnic minority communities,¹² in which members of the Bangladeshi and Pakistani communities in Newcastle contributed to study development, implementation, and analysis (for details of the Bangladeshi and Pakistani communities in Newcastle, please see box 1 Bush *et al*). Six male and seven female bilingual community researchers recruited for, and undertook in-depth interviews and focus groups with members of their own communities, usually of the same sex, during 2000–2002. The community researchers translated interview transcripts, where necessary, into English. Around 20% of translated transcripts were sent to an independent translation agency to check consistency. JB interviewed professionals working with the South Asian communities.

Data generation

We completed 12 focus groups (eight groups with men, including mainly smokers and some former smokers; and four groups with female smokers and non-smoking relatives of smokers) and six in-depth interviews with people who felt unable to participate in a group discussion. Participants were

purposely sampled using the same informal recruitment methods used in phase 1 of the research,^{7 12} ensuring approximately equal proportions of Bangladeshi and Pakistani representing the adult age range. A total of 41 Bangladeshi and 32 Pakistani adults participated (see table 1 below), around half of whom had already participated in phase 1 of the research exploring their attitudes to smoking and health.⁷ Eight interviews were conducted with professionals, including three GPs, one practice nurse, two health promotion specialists, one pharmacist, and one community development worker.

Analysis

We analysed transcripts to identify recurring, emergent themes using constant comparison of the interview and focus group transcripts, and examination of deviant cases.^{13 14} Fieldwork and analysis continued until no new themes were emerging. JB led the analysis, with the community researchers and members of the research team reading a proportion of transcripts to agree a thematic framework for coding, thus improving reliability. We used NUD*IST 4 textual analysis software to aid analysis. To refine our interpretations, we discussed the analysis at a meeting with local community workers and organisations.

RESULTS

Table 1 shows the demographic characteristics and smoking status of all community participants.

The views of Pakistani and Bangladeshi community members

Motivation for and barriers to quitting smoking

Over 60% of male Bangladeshi and Pakistani participants had tried to quit smoking on at least one occasion, mostly aged under 45, and many others said they would like to quit smoking. However, few had been successful and most had relapsed within hours or days (box 1).

One reason for lack of success, particularly in young Bangladeshi men, was pressure from smokers. Stressful events often interrupted cessation attempts, and quitting smoking made it more difficult to cope with stress. Participants also often suffered physical and psychological withdrawal symptoms (box 1).

Table 1 Demographic characteristics and smoking status of South Asian community participants. Values are numbers (percentages) of participants

	Bangladeshi (n = 41)	Pakistani (n = 32)
Age (years)		
18–29	14 (34)	12 (38)
30–49	22 (54)	14 (44)
50+	5 (12)	6 (19)
Men	29 (70)	24 (75)
Women	12 (30)	8 (25)
Household tenure		
Owned	16 (39)	13 (43)
Rented	25 (61)	19 (57)
Age left full time education (years)		
Did not attend school	0	2 (7)
Under 16	10 (24)	5 (17)
16	18 (43)	12 (37)
17–18	10 (24)	11 (33)
over 18	3 (30)	2 (7)
Smoking status		
Current smoker	32 (78)	23 (73)
Non-smoker	9 (22)	9 (27)

Box 1 Experiences of quitting smoking

"Yes I tried [to give up smoking] once and success lasted only two weeks. ...friends offered me a cigarette. I took one. I said oh right—I didn't care" (current smoker, focus group of Bangladeshi men, aged 30s–40s, in English).

"I decided that I was not going to smoke. I managed without cigarettes the whole day. But then at the end of the day I would start arguing with the family for one reason or another reason, and then would start smoking again" (current non-smoker, interview, Pakistani man, aged 40s, Urdu).

"Three years ago from today I announced amongst my friends that I am quitting cigarettes... I passed one day. The second day was okay. The third day I felt myself lifeless, that my brain is not working when I was driving. I did not have any sense" (current smoker, interview, Pakistani man, aged 30s, in Punjabi).

"I stopped for a few days although I felt pain in my body" (current smoker, focus group of Bangladeshi men, aged 30s, in Sylheti).

"I always think to give up smoking but my bowel does not get clear if I do not smoke just before going into the toilet" (current smoker, interview, Bangladeshi man, aged 50s–60s, in Sylheti).

Reasons why participants had not tried to quit smoking

Around 40% of participants, particularly elders, had never tried to quit smoking, although some had considered it (box 2). Participants expressed a range of rationalisation strategies to justify not quitting. Young men who enjoyed smoking when they were socialising felt they were in control of their smoking, they only smoked occasionally, it was not affecting their health to a significant degree, and they would quit in the future. Other smokers drew on examples of friends or relatives who remained healthy despite smoking. Smoking was also viewed as a coping strategy for dealing with everyday stresses, especially among restaurant workers and owners (box 2).

Reasons for wanting to quit smoking

Most participants gave interrelated explanations for wanting to quit smoking. Health risks associated with smoking were the most commonly cited reason (box 3). Younger male participants described how they wanted to adopt a healthier lifestyle. Participants, or their relatives, who had suffered from an illness perceived to be caused by smoking, had also been motivated to quit. Some participants had stopped smoking on the advice of their doctor, although many of these participants, particularly elders, had failed to act on this advice. Symptoms experienced by participants who smoked were also attributed to smoking, such as difficulty breathing, wheezing, or pain. There were also some concerns about the dangers of passive smoking.

Pressure from family members was another reason for wanting to quit smoking (box 3). In particular, we found that children (especially daughters) would put pressure on their fathers to quit (in households where such pressure was acceptable). Children were reported to be well informed of the risks of smoking. Although there was much peer pressure on men to smoke, male friends would also sometimes exert positive pressure to quit if they were non-smokers, or had previously quit smoking themselves (box 3).

Box 2 Reasons for not attempting to quit smoking

"I don't want to give up. I am happy smoking, and I don't want to be unhappy" (current smoker, interview, Pakistani man, aged 30s, in English)

"Well I think we are all in our forties and I think the majority of us here smoke. It just proves that forty plus people, the majority are on cigarettes and have no intention of kicking the habit" (current smoker, focus group of Bangladeshi men, aged 40s, in English).

"Well I would like to say that smoking is a very, very bad habit but I just can't stop smoking at the minute. I am enjoying myself too much, because of the drink and going out clubbing. And it is like a very big social thing, smoking cigarettes while you are drinking. It blends together one hundred percent. But I will eventually give up definitely" (current smoker, focus group of Pakistani men, aged 16–20s, in English).

"The Bangladeshi people living and working in this country, the males smoke more... ninety percent are involved in the catering industry which is very unsociable hours to work. And they have much less time to play" (current smoker, focus group of Bangladeshi men, aged 30s–40s, restaurant owners, in English).

Although never cited in isolation, concerns about the cost of cigarettes were often linked to other reasons for wanting to quit. However, others felt that smokers were prepared to buy cigarettes whatever the price (box 4).

While smoking is not explicitly prohibited in the Koran, it is not fully accepted within the Muslim religion.¹⁵ This issue was raised by all age groups but was a particularly strong theme for older participants. Many smokers had cut down or stopped smoking during Ramadan (box 4).

Experience of informal methods for quitting smoking

Participants of all ages had tried to quit without using any formal intervention, primarily using willpower. Those who had been successful tended to be admired and respected and were seen to be strong and highly motivated. However, mostly, trying to quit using willpower alone had not been successful (box 5).

Participants also used chewing gum (not NRT) and ate fruit or sweets to keep their mouth occupied. Participants tended to develop their own personal routines that worked for them.

Many male participants had tried to quit during the holy month of Ramadan. However, often they only succeeded in altering the hours during which they smoked or cutting down on cigarettes smoked. Once Ramadan was over, most went back to their usual smoking routine. Some participants had switched to a lower tar cigarette. Some felt that cutting down did not help their health or the addiction (box 5).

Attitudes to and experience of formal smoking cessation interventions

Experience of formal interventions was considerably less common than informal approaches. The most commonly experienced intervention was NRT patches, although sprays and gum had also been tried. However, most participants had negative views of NRT, either because they felt it was still putting an addictive substance into the body, or because it had been unsuccessful. NRT was viewed as expensive and requiring willpower to be successful. Few were aware of the evidence for effectiveness of pharmacological interventions or

Box 3 Health and interpersonal reasons for quitting smoking

"At the time I was quite into weight training things like that etc. I made a strict regime for myself to do regular exercising and therefore, you know, part of that was to stop smoking as well. To have a regular, very, very healthy period of living, just to see how it affected me" (current smoker, interview, Pakistani man, aged 20s, in English).

"When I found out [I had the heart problem] even then I had difficulty with stopping. And when I became quite sick, all the time I would light up a cigarette. And I thought well I have to you know give up. So one day, I just had a cigarette in my hand and I threw it away, and that's it. I have never smoked since." (ex-smoker, focus group of Bangladeshi men, aged 30s–40s, in English).

"Well in my family my father was a heavy smoker. I think he smoked about forty or sixty a day. But he suffered a stroke in 1994. Since then he hasn't touched a cigarette" (non-smoker, focus group of Bangladeshi men, aged 30s–40s, in English).

"I cut down in the house because if I smoke in the house then my children will get damaged, their health you know. Nobody else smokes in my house, only me. It's stupid. That's why I cut down" (current smoker, focus group of Bangladeshi men, 30s–40s, in Sylheti)

"The children speak angrily to their father as well, 'If you get cancer, don't blame me tomorrow!' because of the awareness from school and leaflets, the TV at a young age, twelve or thirteen. They are not going to try. Not yet at least anyway. So they are encouraging them to give up" (non-smoker, focus group of Pakistani women, aged 20s–50s, in Punjabi).

"My friends used to criticise me and say, 'you don't have to smoke'... No one amongst my friends smokes cigarettes. All the friends were objecting to me smoking in front of them." (current smoker, interview with Bangladeshi man, aged 30s, in Sylheti).

that they could be obtained on NHS prescription. A small number of participants had tried Zyban (Bupropion), though there were fears of publicised side effects (box 6).

Some participants had tried to quit following the advice of a doctor, although many were critical of their GP's response when they announced they wanted to quit. Some felt their GP was an inappropriate source of advice. Practice nurses were viewed as having a role in supporting smoking cessation, although few participants had received their help (box 6).

The views of health professionals

The most common barrier to helping people quit was lack of time; to give advice, counselling and support on smoking cessation was viewed as taking more time than GPs typically have during consultations. It was also felt that many Pakistani and, particularly, Bangladeshi men do not have time to visit their GP for help with quitting. Quitting smoking was also not perceived as a priority for them. While older men were thought to be more willing to try quitting if they had a smoking related condition, young men were seen as less motivated, although this was also viewed as a problem generally with young men (box 7).

Language barriers were often mentioned in relation to smoking cessation. Very few general practices had staff who

Box 4 Financial and religious reasons for quitting smoking

"[people give up smoking because of] health and basically more money for you in your pocket. As simple as that. But I think they are concerned more about their health first" (current smoker, focus group of Pakistani men, aged 20s, in English).

"I used to smoke but I have given up smoking about 12 years ago during Ramadan. Ramadan helped me to give up smoking really. The other thing, when I bought the shop I noticed that I was making about 15p [pence] per packet. Then I thought how much it costs for the effect of cigarettes. It was costing too much at the time, and I thought that if I keep smoking then it's going to cost me too much money so I gave up" (ex-smoker, focus group of Pakistani men, aged 20s–50s, in English).

"I asked my friend how he managed to give up smoking. He said when he had been on a pilgrimage to Mecca and Medina, and used to smoke in Medina, other people used to hate him... he was thinking that the prophet of Almighty Allah did not smoke, so why should he keep that bad habit? Then he gave up smoking. Listening to his story of giving up smoking I planned to do something like him. And coming back home I promised to give up. Since then I have never touched it" (ex-smoker, focus group of Bangladeshi men, aged 40s–80s, in Sylheti).

"I was looking through an Islamic CD-ROM and I noticed there was an article on smoking... it also had something on weakness of faith and it was the two intertwined. And I remember reading about it and went through all of it. And basically it's true... I have shown it to a couple of friends, who have also stopped because of that" (ex-smoker, interview, Bangladeshi man, aged 16–19, in English).

Box 5 Informal methods used to help quitting smoking

"My cousin said my uncle had to quit [smoking] and he's probably still choking for one really, at the back of his head. But also at the back of his head it will be like, 'oh I don't want one because it's bad for my health'. He has been off cigarettes for years and years. But he doesn't wear patches. It's all about willpower" (non-smoker, focus group of Pakistani men, aged 16–20s, in English).

"...it took two days of willpower, real bad days... But after the two days I was giving up" (current smoker, interview, Bangladeshi man, aged 16–19, in English).

"[when I am trying to give up smoking I try] to forget about it, so that I do not smoke. I have something else instead. For example, instead of cigarettes I have fruit" (current smoker, interview, Pakistani woman, aged 60s, in Urdu).
 "I still keep trying to give up smoking. It is Ramadan now. During this period I am trying every day not to smoke. But as soon as I break my fast the first thing that I need to do is to smoke. However, I will continue trying" (current smoker, interview, Pakistani man, aged 40s, in Punjabi).

"...I made a concerted effort. I didn't want to smoke, so I didn't smoke. It's as simple as that. After the two years I wanted to start again, so I did. It may sound silly, but I took to smoking more healthily. I smoke a lower tar cigarette and I tried not to smoke right to the end and let them burn a bit more so you know there's not as much tar intake" (current smoker, interview—Pakistani man, aged 20s, in English).

"In my own experience there is no point in cutting down because you are still putting nicotine into your body" (non-smoker, interview, Bangladeshi man, aged 16–19, in English).

could speak Sylheti, Punjabi or Urdu. Some practices employed interpreters, but associated difficulties, particularly the time required and difficulties of accurately conveying meaning, were described. The fact that many interpreters are young and women was perceived to cause concern for older, male patients.

One female GP talked about the difficulties of relating to Bangladeshi and Pakistani men, with whom she felt she shared "no common ground". In contrast a bond between GP and patient was built up when women came into the practice with their children or in relation to pregnancy.

Some professionals felt there were religious and cultural barriers to undertaking health promotion with Bangladeshi and Pakistani people, because they are "fatalistic" and tend to have a view of health as controlled by Allah. Some professionals felt this meant Bangladeshi and Pakistani people were less willing to take control of their health (box 7).

While most professionals felt that they needed more training in how to offer effective smoking cessation services, particularly for South Asian communities, time constraints meant that few had been able to attend such training (box 7). Only one of the health professionals interviewed was aware of the local designated smoking cessation service for ethnic minority groups.

DISCUSSION

Although examples of "good practice" in smoking cessation interventions for UK South Asian communities have been

published,^{8–10} there are no published outcome evaluations, and there has been little systematic research on the experiences of community members or professionals on which current tobacco control policy and practice can be based.⁷ Our research aimed to help address the latter need by exploring attitudes to smoking cessation among community members and professionals.

This study is not without its limitations; in particular the findings may not be generalisable to other ethnic minority communities.⁷ However, it was conducted using a participatory approach¹² and our community participants were broadly representative of the communities from which they were drawn, which have characteristics similar to equivalent ethnic minority communities across the UK.^{4,7}

Three tiers of stop smoking services have been developed throughout primary care in the UK since 1999: brief, opportunistic advice; regular behavioural counselling, with or without drug therapies; and intensive behavioural counselling for individuals or groups, with or without drug therapies.¹⁶ At the time of the fieldwork, a number of bilingual smoking cessation advisors from the South Asian communities were being trained as part of local smoking cessation services.⁶ However, we found little evidence that community participants were either aware of or had benefited from these services. In particular, primary care staff seemed unable to take advantage of the training on offer, largely because of time constraints.

Box 6 Attitudes to and experience of formal smoking cessation interventions

"Well I think it is mainly the willpower. If somebody wants to give the cigarettes up it depends how strong he is... nowadays there are lots of expensive cigarette patches and everything on the market. I don't believe they can help somebody to stop smoking if they don't want to" (current smoker, interview, Bangladeshi man, aged 30s, in English).

"...the last time I was telling my doctor I was trying to give up he says 'good luck'. That's the only thing he said... he never actually gave me a leaflet or tried to tell me the best way of going about it, you know" (current smoker, focus group of Pakistani men, aged 16–20s, in English).

"the doctor put me in for an appointment with the nurse... and the nurse has been very supportive" (current smoker, focus group of Pakistani men, aged 20s–50s, in English).

"I do not feel comfortable to go to my GP for giving up smoking because it takes so long making appointments and then waiting 45–50 minutes to see the doctor" (current smoker, focus group of Bangladeshi men, aged 30–39, in Sylheti)

"The only thing they [doctors] would say is 'go to the chemist, there's some nicotine patches'. You go there and they turn around and say they are about twenty pounds or something... I'd rather smoke than spend... twenty pounds" (current smoker, focus group of Bangladeshi men, aged 20s, in English).

"You can't get nicotine patches on the NHS" (current smoker, interview, Bangladeshi woman, aged 20s, in English).

"I never tried the [NRT] patches but I have tried the [NRT] chewing gum... I took one but it started giving me headache, you know, because a lot of nicotine comes in your mouth regularly. So it has to be a balanced kind of thing... and then I tried one of the patches. To me the patches don't do anything (current smoker, focus group of Pakistani men, 30s–60s, in English).

"I am quite sceptical about tablets and stuff so I wouldn't want to get into that habit. I wouldn't be happy about using Zyban" (current smoker, interview, Bangladeshi woman, aged 20s, in English).

Attitudes to quitting smoking

In contrast with previous reports on smoking in South Asian communities,^{10, 17} we found motivation to quit was high. There were four interrelated reasons for wanting to quit: health concerns; financial reasons; pressure from family and friends; and religious reasons. Apart from religious reasons, these motivations have been reported in research from the white population in the UK.¹⁸ Religion seemed to affect elders in particular, who expressed less internal control over smoking, citing external forces, such as Allah.

Although most smokers had tried to quit more than once, most had failed. Barriers to success included being tempted by other smokers, work and family stress, and withdrawal symptoms. Similar barriers to smoking cessation have been highlighted in other studies of South Asian communities¹⁷ and the white population.^{19–21}

Our findings on attitudes to smoking cessation among community members extend our findings on cultural understandings of tobacco smoking⁷ and provide a detailed

Box 7 Barriers to effective smoking cessation perceived by professionals

"I think [the main barrier] is lack of time. We don't have time to counsel" (interview, male GP).

"...a lot of the young men are smoking, as far as I can see, extremely heavily and... I can think of a few middle age men who are perhaps on patches. But I can't think of any young men who I have actually managed even to get them to stop and think... I just feel like we are twenty... thirty years back. A few of the older Asian men who have got diabetes, they have got skin and heart disease and are beginning to sort of listen. But I just feel that the basic message is not getting across to the Asian community... (interview, female GP).

"Every person who needs interpreting is a double appointment. So if I do a coronary heart disease clinic... it's forty-five minutes because of the interpreter. Health checks are usually twenty minutes... we are the biggest users of the interpreter services... and again, if it's not an independent interpreter you can tell. You get three words to your three sentences... Because it's like anything, it could be something that they just don't want somebody else to know" (interview, female practice nurse).

"you're only going to get advice if you've got a doctor that speaks your language... or if you speak English" (interview, male community worker)

"...with the interpreters, on the whole, the majority of people are well-motivated young Asian women. And they are very good at their job and I am not criticising them. But older Asian men do not like young Asian women interpreting for them. I mean I had an elderly Asian gentleman literally spitting mad at me because I couldn't provide an elderly Asian male interpreter. And you know at the end I turned and said look, please go to training you know. If you can learn English then come and work as an interpreter. But he just couldn't grasp the fact that why should a man in his position take on a job of that nature (interview, female GP).

"...in order to communicate effectively with people's lifestyle as opposed to just giving tablets you've got to be alongside to a degree. You've got to believe that you've got some common ground... The women are easier because... the young women who come in, they are getting pregnant, you are seeing them for ante-natal, you can cuddle their babies, you know. But the men, you find yourself sitting here and you do your best but you think I am not actually getting from this guy any feeling that we're relating as people. And until you can get that, your power to actually encourage people to rethink things is very limited" (interview, female GP).

"Yeah, there was smoking cessation courses and people were asked if they wanted to go and do the intermediate [level] and stuff. And at the time I was on my own and then we were leaving to go to [train as] nurse practitioner and I couldn't be released. To be honest I haven't the time to go on the course, so no we have had no formal training" (interview, female practice nurse).

"They think if they get cancer and other sorts of things they have done something wrong in their life. It doesn't come from what they are doing to themselves it comes from Allah. So they've got no connection" (interview, female practice nurse).

What is already known on this subject?

- Smoking prevalence is comparatively high among Bangladeshi and Pakistani men in the UK, but presently low among women from these communities
- Ethnic minority groups are not defined as a target group in the UK government's tobacco control strategy, which forms the foundation for smoking cessation services
- Current evidence of effectiveness for smoking cessation interventions is not derived from studies involving the UK's main ethnic minority groups
- Smoking is seen as socially acceptable among Bangladeshi and Pakistani men, but is associated with a sense of cultural taboo among women from these communities
- Motivation to quit among Bangladeshi and Pakistani smokers is thought to be high, but access to services and quit rates are thought to be low

picture of the challenges faced both by South Asian smokers and by the professionals trying to help them.

Experience of quitting smoking

Methods used to quit smoking by community members focused more on the concept of willpower than has been found in the white population, an approach that is thought to be largely ineffective.^{21–25} Quit rates were, unsurprisingly, felt to be low.

There was limited experience of using health service interventions. In the general population of the UK, around 40% of smokers seek help or advice from health professionals each year,²⁶ but few community members in this study had sought advice from their general practice. NRT had been used by some participants but, as has been found in studies of both South Asian¹⁷ and white populations,²⁷ it was generally viewed as having a low success rate. Hardly any participants had any experience of Bupropion (Zyban), which was felt to have significant side effects.

For these communities, strong barriers to smoking cessation in primary care were identified. Smokers did not tend to view the GP as someone to go to for advice on quitting smoking, as a GP's role was predominantly viewed as giving advice and treatment to the sick. Some had found primary care services inaccessible, because of time constraints, unfamiliarity with staff, language or cultural barriers. As found in other research, primary health care staff were often reluctant to raise the topic of smoking during consultations, as they feared this could cause confrontation with patients.^{28–29}

Health professionals identified a range of interrelated and reinforcing barriers to undertaking effective smoking cessation with Bangladeshi and Pakistanis. These included time and language barriers (including the potential difficulties of working with interpreters); religious and cultural barriers; attitudinal problems (a perception that few Bangladeshi and Pakistani men, particularly young men, felt quitting smoking was a priority), and lack of time and resources to attend smoking cessation training sessions.

Another difference between the smoking cessation experiences of our participants and those found in white communities was the influence of religion: both Islam in general and the incentive to quit during the holy month of Ramadan were felt to be important, although few had been successful in quitting altogether during Ramadan.

Implications for policy, practice, and research

Our findings suggest that UK Bangladeshi and Pakistani adults, in particular men, are not currently benefiting from

What does this study add?

- Bangladeshi and Pakistani smokers reported few successful attempts to quit, and most have relied on willpower alone
- Barriers to quitting successfully included insufficient use of professional advice and smoking cessation aids, pressure from family and friends, stress caused by families and work, and withdrawal symptoms
- Bangladeshi and Pakistani smokers have low levels of awareness of, and contact with formal smoking cessation services and little acceptance of their value
- Professionals perceived the barriers to delivering effective smoking cessation for Bangladeshi and Pakistani patients to include lack of time and relevant training, and cultural barriers involving language and religion.

the widespread smoking cessation services that have been implemented across the UK as a part of the national tobacco control strategy since 1999,¹⁶ although many of their attitudes to and experiences of quitting show remarkable similarities with those of the general public. With the introduction of the Race Relations (Amendment Act) 2000³⁰ public authorities have an obligation to promote racial equality in access to smoking cessation services. Ethnic minority groups (particularly those with high smoking prevalence) should be given greater attention in national tobacco control policies, as have women, the socioeconomically disadvantaged, and children.¹⁶

Government, together with health promotion agencies, strategic health authorities, primary care trusts, and local government should work together to develop effective tobacco control policies and interventions for smoking cessation among South Asians, involving south Asian

Policy implications

- Ethnic minority groups (particularly those with high smoking prevalence) should be given special attention in national tobacco control policies, as have women, the socioeconomically disadvantaged and children.
- Governments, together with health promotion agencies, health authorities, and local government should work together to develop effective tobacco control policies and interventions for smoking cessation among ethnic minority groups. Where appropriate, agencies should involve ethnic minority communities in the design, publicity, implementation, and evaluation of such interventions.
- Policies and interventions need to be developed to help health professionals overcome the barriers they experience in communicating with ethnic minority groups, including appropriate interpreting services and training in cultural competency.
- Research policy needs to reflect the needs of ethnic minority groups. For example, smoking cessation interventions of known effectiveness need to be adapted for use with ethnic minorities, based on a detailed understanding of attitudes to smoking and smoking cessation among relevant communities and the professionals who serve them.

communities in their design, publicity, implementation, and evaluation.

More also needs to be done to overcome the barriers experienced by health professionals, in particular those relating to communication with ethnic minority groups. There is significant under-provision of interpreting services currently and norms need to be established for the availability of such services at national and local levels. More training should be available for primary care staff on how to communicate effectively with South Asian people and how most effectively to offer effective stop smoking interventions to these groups.

Such developments in practice need to be underpinned by further research, using a staged approach.³¹ Firstly, methods to study smoking behaviour in ethnic minority groups need to improve.³² Secondly, interventions of known effectiveness need to be made more accessible to UK ethnic minorities, based on a detailed understanding of attitudes to smoking and smoking cessation among relevant communities and the professionals who serve them, and then rigorously tested for acceptability, efficacy and effectiveness. A randomised controlled trial of community smoking cessation workers for South Asian men has been funded as a part of the National Prevention Research Initiative in the UK³³ to build on the work reported here.

ACKNOWLEDGEMENTS

We thank the following people: the community and professional research participants; Jean King from Cancer Research UK for her guidance throughout the project; Terry Lisle for secretarial and administrative support; all members of the project Steering Group, particularly Zakia Chowdhury, Iain Miller, Lucy Hall and Anu Kulkarni; Azad Kashmir Women's Association (Leeds) and the Newcastle City Council Civic Centre Language Department for translations; North Tyneside Open College Network for help, support and assistance with the training programme; South Tyneside College Languages Department for undertaking and facilitating community researcher language tests; Veena Bahl from the Department of Health for instigating the cancer research programme and organising support; the Pakistani Muslim School, Roshni, and the Bangladeshi Workers Association for their time and allowing us to use their facilities for running focus groups. Tim Lancaster, Mark Johnson, and Andrew Molyneux provided helpful comments on an earlier draft.

CONTRIBUTIONS

MW was principal investigator. JB contributed to the supervision, management and training of the community researchers, design of research materials, data collection, data validation, and took the lead in data analysis and report writing. RB, MW, JK and JR contributed to the study hypothesis, research design, data analysis, research materials and data validation; commenting on drafts of the text; and gained funding for the research. JK and JB designed the training programme. MW drafted this paper. Jane Harland contributed to the research design and funding proposal. All authors are study guarantors. Thirteen community researchers organised, recruited, undertook and translated in-depth interviews and focus groups, facilitated by JB. The community researchers also contributed to developing interview topic guides, publicity for the study, participant recruitment strategies and data analysis. The community researchers were Masuk Ahmed, Asif Shariff, Shubh Ghai, Khalid Mohammed, Akla Rahman, Anita Sarkar, Neelam Varma, Rushna Ahmed, Afzal Choudry, Afroz Qureshi, Rurkinder Kaur, Momotaj Rahman, and Jamal Sarwar.

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Funding: Cancer Research UK and the Department of Health. The guarantors accept full responsibility for the conduct of the study, had access to the data and controlled the decision to publish. All authors are independent of the funding source.

Competing interests: none.

Ethical approval was obtained from Newcastle and North Tyneside joint local research ethics committee.

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